STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445511	A. BUILDING 01 - MAIN B. WING	06/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF OOLTEWAH	5911 SNOW HILL ROAD OOLTEWAH, TN 37363

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure listed fire stopping systems were used in penetrations in 2 of 5 observed. 8.2.3.2.4.2* The findings include: 1. Observation and interview with the maintenance director, on June 16, 2014 at 9:57 a.m., revealed intumescent fire barrier sealant was painted in a penetration through 1 hour fire rated wall in mechanical room 3. 2. Observation and interview with the maintenance director, on June 16, 2014 at 10:18 a.m., revealed intumescent fire barrier sealant was mixed with different product with-in the same penetration located in the mechanical room on the 300 hall. These findings were verified by the maintenance director and acknowledged by the facility administrator during the exit conference on June 16, 2014.	K 130	K130 1. Maintenance Director removed and replaced painted fire barrier sealant in 1 hour fire rated wall in mechanical room #3 and repaired and replaced mixed fire barrier sealant with-in same penetration in mechanical room on 300 hall. 2. All other one hour fire walls were inspected for painted or mixed fire barrier sealant and were in compliance. 3. The Maintenance Director conducted an educational in-service to the maintenance staff regarding not painting or mixing fire barrier sealant. The maintenance director or designee will inspect one hour fire walls once per month for three months and once per quarter to ensure compliance. 4. The maintenance director will report his inspection results to the Quality Assurance Committee for three months. The Executive Director will monitor for compliance.	07/25/201

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jaimme Preston	Executive Director	7/3/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.